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RECENT AND FORTHCOMING MEETINGS

1950

4-11 October	WHO Expert Committee on Insecticides, second session, Geneva
9-18 October	WHO Expert Committee on International Epidemiology and Quarantine, third session, Geneva
30 October-4 November	WHO Expert Committee on the Unification of Pharmacopoeias, seventh session, Geneva
1-6 November	WHO Expert Committee on International Epidemiology and Quarantine, Legal Subcommittee, third session, Geneva
6-7 November	WHO Expert Committee on the Unification of Pharmacopoeias, Subcommittee on Non-Proprietary Names, first session, Geneva
6-11 November	WHO Expert Committee on Biological Standardization, fourth session, Geneva
6-14 November	WHO/FAO Expert Advisory Panel on Brucellosis, first session, Washington
27 November-9 December	Commission for Technical Co-operation in Africa, WHO Malaria Conference in Equatorial Africa, Kampala, Uganda
December	Meeting of Experts of WHO Advisory Panel on Public-Health Administration, Geneva
11-16 December	WHO Expert Committee on Malaria, fourth session, Kampala, Uganda
11-16 December	WHO Expert Committee on Mental Health, Subcommittee on Alcoholism, first session, Geneva
11-16 December	WHO/FAO Consultant Group on Bovine Tuberculosis and Other Zoonoses, first session, Geneva

1951

22 January	WHO Executive Board, seventh session, Geneva
April, tentatively	WHO Expert Committee on International Epidemiology and Quarantine, fourth session, Geneva
April	WHO Expert Committee on the Unification of Pharmacopoeias, eighth session, Geneva
April	Joint FAO/WHO Expert Committee on Nutrition, second session, Rome
9 April	WHO Special Committee to consider the Draft International Sanitary Regulations prepared by the Expert Committee on International Epidemiology and Quarantine, Geneva
April or May, tentatively	WHO Expert Committee on International Epidemiology and Quarantine, Legal Subcommittee, fourth session, Geneva
7 May	Fourth World Health Assembly, Geneva

WHO TUBERCULOSIS RESEARCH OFFICE, COPENHAGEN

The WHO Tuberculosis Research Office was established in February 1949 to study the problems of tuberculosis, particularly in connexion with mass BCG-vaccination. During the past 20 months its work has been extended to many countries participating in the BCG campaign and, in a number of countries, research projects have been developed in co-operation with national or local health organizations. Special mention should be made of the close co-operation with the Joint Enterprise for the international BCG-campaign, the Statens Seruminstitut, and the National Health Service of Denmark.

The activities of the Research Office can be divided into four major categories :

1. *Direction of statistical work of the BCG campaign and preparation of material for documentation*

From the beginning of the campaign it was recognized that there would be a most unusual opportunity for worldwide collection of useful information on tuberculin-sensitivity, and that a statistical report of the vaccination and the results of tuberculin-testing in each country would be best prepared by a central office as a permanent record for international comparison and follow-up. A statistical section for the BCG campaign was set up in the Research Office to perform the following functions :

(*a*) Direction and supervision of the statistical work of the campaign in individual countries. A detailed statistical manual has been issued for use in the field.

(*b*) Training of statisticians for field assignments and training and supervision of national and local statistical personnel.

(*c*) Preparation of monthly, annual, and final reports for individual countries. The final report for the campaign in Czechoslovakia was recently published, and the preparation of several others is well under way. Tuberculin-sensitivity curves by age were issued for 12 countries in the campaign.

By the end of September 1950, the Research Office received from the field detailed statistics on tuberculin-testing of 16,289,586 persons and vaccination of 8,136,857 non-reactors, representing, respectively, about 55% of the tested and 60% of the vaccinated in the campaign. At the time of writing this report, statisticians or trained statistical supervisors were working in Austria, Ecuador, Egypt, Greece, India, Mexico, and Syria.

In February 1950, a special statistical office was set up in Vienna, in co-operation with the Austrian Ministry of Social Welfare, for collection of statistical data from the campaign. To date, 350,000 vaccination records

have been transferred onto punch-cards. Statistics on tuberculin-testing and vaccination, including post-vaccination retesting, are being tabulated.

Lately, arrangements for making a sampling survey of post-vaccination allergy in Greece were made. Retesting by specially trained teams has begun in the schools in Athens. Emphasis is placed on determining the duration of tuberculin allergy and variations which may have resulted from different lots of BCG used.

2. *Evaluation of effect of mass BCG-vaccination on prevention of tuberculosis*

The Research Office has, from the start, stressed the importance of a controlled study in the evaluation of the effect of BCG vaccination on a population of a sufficient size, in which the non-reactors are vaccinated alternately at random ; it proposed that such a study be undertaken along with the present BCG programme. So far this idea has not met with success because health authorities find it difficult to subject populations to such experiments.

An evaluation project of a different kind has been developed in Finland. Punch-card copies of about one million vaccination records have been made to form a national roster. This will permit direct matching of current death reports from the National Office of Vital Statistics, and observed tuberculosis mortality of the vaccinated can be compared with that of the natural reactors to tuberculin and with expected trends of tuberculosis mortality in the general population based on pre-vaccination experiences. Supplementing this central roster a detailed analysis has been made of the Finnish mortality from tuberculosis, in order to work out forecasts for comparison with observed mortality-rates in years to come.

Finland has certain special features which are favourable for the project in question. Vaccination was quite complete and was carried out in a relatively short period of time, about one and a half years in 1948-1949. There is a strong centralized organization for tuberculosis control, and its leaders are interested in international collaboration in tuberculosis research. The Finnish tuberculosis mortality is comparatively high—130 per 100,000—and mortality statistics are available for a long period of years. If the effect of mass BCG-vaccination on tuberculosis mortality can be demonstrated at all without a comparable control group, it should be possible under the conditions obtaining in Finland.

A similar roster is being set up in Denmark, at the request of the Danish National Health Service, for the National Tuberculosis Mass Campaign, which aims at a complete examination of a population of 1,400,000 between the ages of 1-6 and 15-34 by tuberculin-testing and vaccination, as well as x-ray examination of adolescents and adults. Denmark has the lowest mortality in tuberculosis among nations, 19 per 100,000 in 1949. Its tuberculosis control is outstanding. Local tuberculosis dispensaries are usually under the charge of specialists of high standard. Diagnosis is

FIG. 1. TUBERCULIN-TESTING IN INDIA

Dr C. E. Palmer, Director of the WHO Tuberculosis Research Office, performing a tuberculin-test during his visit to India

proved by bacteriological findings, a single national laboratory being responsible for the work. Registration of tuberculosis morbidity and mortality is as complete as is practically possible. The country is small, and a national roster of the tuberculin-tested and the vaccinated is of reasonable manageability. The programme is especially suitable for the study of the effect of the BCG vaccination on tuberculosis morbidity.

3. *Studies on BCG vaccine and techniques of tuberculin-testing and vaccination*

Since November 1949, a series of investigations has been carried out as a co-operative undertaking with the Joint Enterprise and the Danish Statens Seruminstitut to develop methods for field study and comparison of BCG vaccines, and to elicit the effects of certain factors on the allergy-producing quality of the vaccine. In these studies great care has been directed towards securing adequate comparability of test subjects, uniformity of techniques and procedures, accuracy of observation and measurement, and avoidance of personal bias. The test individuals are exclusively school-children of 7-14 years of age, living in rural districts where the prevalence

of tuberculous infection is very low. Not only are uniform techniques and procedures maintained throughout these studies, but the same operations are performed, as far as is practically possible, by the same individuals. All vaccines used are labelled in a code, and their identities are not known to the field staff who do the testing and vaccination. Readings of tests are recorded by clerks so that the reader has neither the necessity nor the opportunity to obtain any information on the individual record.

Results to date indicate that the age of the vaccine, the storage temperature, and, within the limits studied, the dosage of vaccine effect only slight differences in the allergy-producing quality of the vaccine used. Essentially all vaccinated children have become reactors 8-10 weeks after vaccination, so far as the usual criteria of the size of a positive reaction are accepted.

There are, however, small differences in the character of the reactions, which are strongest in children vaccinated with vaccine four times the standard strength and weakest in those receiving fractional strengths. The striking finding is that there is no significant decrease in the average size of reactions with the increasing age of vaccine up to 29 days, both with refrigerated vaccine and with vaccine stored at 20°C. Even storage at 37°C. for five days did not disturb the effectiveness of the vaccine in producing tuberculin allergy.

Differences between vaccines from different production centres are apparent with respect to the total spectra of tuberculin-sensitivity which are not only quantitative but qualitative as well. It seems that the size of the post-vaccination tuberculin reaction differs less markedly for the different vaccines than the qualitative character of the induration they produce.

So far seven projects have been carried out on a total of about 15,000 children, and the retesting of the last group will be made shortly. The first of a series of papers from these studies has recently been published in the *Bulletin of the World Health Organization.*[1]

As there is much need for more precise and quantitative methods for field standardization and comparison of tuberculins, plans have been worked out for the development of such methodology through utilization of the facilities of the Danish national tuberculosis campaign and the special vaccine studies. Pilot studies are also being planned to standardize a new lot of tuberculin for use in the international BCG-campaign and for comparison with other tuberculins.

4. *Special research in different areas and peoples*

The study of the specificity of the tuberculin-test and the significance of the non-specific reactions is basic to many clinical and epidemiological

[1] *Bull. World Hlth Org.* 1950, 3, 1

problems and to the proper performance of BCG vaccination. A special research team was in India for six months, from September 1949, and has been in Egypt since April 1950, making observations on the tuberculin-test with different antigens in varying dosages. About 40,000 persons have been tested and BCG vaccination, x-ray examination, and post-vaccination retesting have been carried out on selected groups.

A similar study has been made in Iceland in co-operation with the tuberculosis-control service in that country. Approximately 2,000 persons have been tested using avian, BCG, and other tuberculins. It is hoped that the work will be extended to include epidemiological studies on factors influencing the rapid decline in the incidence of tuberculosis where BCG vaccine has not been extensively used as a prophylactic.

A field station was established this spring in Madanapalle, South India, in co-operation with the Union Mission Tuberculosis Sanatorium, to study tuberculosis in rural India and to investigate problems which have arisen in connexion with the mass BCG-vaccination being carried on in that country. In 1948-1949, the entire population of 14,000 in Madanapalle town were x-rayed, tuberculin-tested, and vaccinated. The present programme includes retesting and revaccination, and extension of mass BCG-vaccination, x-ray examination, and follow-up in surrounding rural communities. In one area the examination of 4,000 persons was recently completed, and basic information has been put on punch-cards for tabulation and analysis.

TUBERCULOSIS CONTROL

During its fifth session, held in Geneva from 11 to 16 September 1950, the Expert Committee on Tuberculosis [1] discussed, in particular, the role and responsibilities of the general hospital in the diagnosis and treatment of tuberculosis, mass radiography, the report of the WHO Tuberculosis Research Office in Copenhagen, compulsory notification of tuberculosis, and bovine tuberculosis.

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[1] The following took part in this session :

Members :

Dr M. S. Abaza Bey, Adviser, Misr Weaving & Spinning Co., Cairo, Egypt (*Vice-Chairman*)
Dr J. I. Baldó, Chief, Tuberculosis Division, Ministry of Health and Social Welfare, Caracas, Venezuela
Dr P. V. Benjamin, Tuberculosis Adviser, Directorate General of Health Services, New Delhi, India
Dr E. Bernard, Professeur à la Faculté de Médecine de l'Université de Paris, France
Dr P. M. D'Arcy Hart, Director, Medical Research Council's Tuberculosis Research Unit, London, United Kingdom
Dr H. E. Hilleboe, Commissioner of Health, New York State Department of Health, Albany, N.Y., USA (*Rapporteur*)
Dr J. H. Holm, Chief, Tuberculosis Division, Statens Seruminstitut, Copenhagen, Denmark (*Chairman*)

Secretary :

Dr J. B. McDougall, Chief, Tuberculosis Section, WHO

Role and Responsibilities of General Hospitals [2]

General hospitals could make an important contribution to tuberculosis control by subjecting admissions, outpatients, and hospital staff to radiographic examination. It would thus be possible to detect unsuspected cases which might spread infection in the general service wards and among the unprotected hospital personnel. This method of case-finding has, thus far, not been used to any great extent. Recent inquiries in the USA have revealed that only about 247 of 4,539 general hospitals have adopted such routine chest examinations, despite the fact that the effectiveness of this practice has been amply demonstrated. In a hospital in New York State, for example, 74% (i.e., 7,187) of the patients were radiographed, and 4% (i.e., 290) showed signs of tuberculosis. In the Chicago University dispensaries, fluoroscopy of the chest has been routine practice since 1942; of 15,000 persons examined, 4.17% (i.e., 626) have shown tuberculous lesions. From these figures and from a previous study carried out in Chicago on 25,000 negroes, it has been estimated that in the USA 600,000 persons undergoing medical treatment for other complaints are suffering from undiagnosed, active tuberculosis.

In most countries the number of beds in tuberculosis sanatoria and specialized hospitals is insufficient. This situation could be relieved by admitting cases of tuberculosis to general hospitals, providing for them separate services, in annexes, special pavilions, etc. Priority of admission should be given to patients whose condition would respond rapidly to treatment such as pneumothorax or chemotherapy. Successful treatment, which would render these cases non-infectious, would reduce the risk of the infection's spreading among other people. Having tuberculosis patients in general hospitals would also be beneficial for teaching purposes ; students would have an opportunity to learn the most modern methods of diagnosis and treatment, and their attention would be directed to a disease which too often remains undetected.

If tuberculosis patients are admitted to general hospitals, adequate measures must, of course, be taken to protect the nursing staff and others who are in contact with them. Regular radiographic examinations, BCG vaccination, and general prophylactic measures have already reduced considerably the risk of infection of hospital personnel. In certain hospitals the risks are no greater than in other comparable population groups.

The Expert Committee on Tuberculosis recommended that the collaboration of general hospitals in detecting and treating tuberculosis be encouraged, that the nursing and other staff be adequately protected against infection, and that cases discovered by hospitals be reported to the local health authorities so that contacts of the patients may be examined.

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[2] The paper considered by the committee will be published in a forthcoming number of the *Bulletin of the World Health Organization.*

Mass Radiography

Mass radiography serves two purposes : first, it permits case-finding at an early stage in apparently healthy population groups ; and, secondly, it is a rapid method of evaluating tuberculosis morbidity in a certain area before drawing up a control programme. However, radiographic examinations do not, in themselves, constitute a sufficient basis for diagnosis ; laboratory tests are necessary for confirmation. In fact, cases of tuberculosis should not be reported to health authorities on the basis of x-ray examination alone.

The committee emphasized that mass radiography is useful only if laboratory and treatment facilities are also available. It was of the opinion that in the underdeveloped countries it would be desirable to combine such examinations with tuberculin-tests.

Research

The committee examined with much interest the report of the WHO Tuberculosis Research Office in Copenhagen. It suggested that research be undertaken to re-assess the value of the oral method of administering BCG. Another subject for research, one of some urgency because of the increasing need for a single pre-vaccination tuberculin-test, is determining an appropriate test-dose for this test. At the meeting of the Joint UNICEF (Medical Subcommittee) and WHO Interim Commission (Subcommittee on Tuberculin-Testing and BCG Vaccination) held in Paris in June 1948,[3] a dose of 10 units of tuberculin (TU) for the final Mantoux test was recommended, and a minimum of 6-mm. diameter induration was set up as the criterion of a positive reaction. The Expert Committee on Tuberculosis proposed that, for the single test, the dose be reduced to 5 TU and that the minimum diameter of induration indicating a positive reaction be fixed at 5 mm. as observed three days after inoculation. In addition, the committee thought it would be desirable to determine what dose of tuberculin should be administered in the surveys which are carried out to determine the incidence of tuberculous infection in a country.

Compulsory Notification

Legislative measures concerning notification of tuberculosis vary considerably from country to country. In some countries, notification of all forms of the disease is compulsory, although not always strictly applied ; in other countries, only pulmonary tuberculosis is subject to notification ; in still others, notification is optional.

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[3] *Off. Rec. World Hlth Org.* **15**, 10

There are often psychological and economic factors which make it difficult to ensure that compulsory notification is observed, especially in places where a feeling of shame is still associated with the disease. In countries where the central and local health-administrations are as yet only slightly developed and where the number of doctors is insufficient, it would be useless to try and enforce compulsory notification. The committee thought, however, that, in spite of the difficulties encountered, compulsory notification has greatly increased the efficacy of control programmes in countries where it has actually been observed. It therefore recommended that countries which have not yet adopted this measure consider doing so, enlisting the collaboration of the medical profession in this effort. The committee was of the opinion that only doctors should be entitled to report the cases and that the notification should specify whether or not tubercle bacilli have been found in the patients' sputum or body-fluids.

Control of Bovine Tuberculosis

As a result of a resolution of the Third World Health Assembly,[4] the committee discussed the question of bovine tuberculosis. Except for the Scandinavian countries, bovine tuberculosis is still a problem of major importance in the remaining northern, western, and some of the southern European countries. In these countries the infection of cattle varies between 20% and 60%, with dairy cattle being the most seriously affected. Cattle in Eastern Europe are less subject to attack ; it is mainly the herds in the vicinity of the large urban centres which are infected. On the basis of the information available, it would seem that the same applies to the Eastern Mediterranean area, and Central South America.

Contact with infected cattle and consumption of food from such cattle involve risks of infection for man. It is now possible gradually to eliminate bovine tuberculosis, thanks to various measures the application of which depends, in part, on the economic situation of the countries concerned. Tuberculin-tests, followed by the slaughter, or separation from the herd, of infected animals, and vaccination with BCG or with the bacilli of murine tuberculosis have already given encouraging results. The final solution of the problem depends upon the combined efforts of agricultural and health authorities. The committee recommended that in each country joint commissions of doctors and veterinarians be set up to study the question and that measures be taken to eliminate bovine tuberculosis, which constitutes a threat to both agriculture and public health.

[4] See resolution WHA3.28, *Off. Rec. World Hlth Org.* **28**, 25.

ANAESTHESIOLOGY TRAINING CENTRE, COPENHAGEN

In the past two years, the Governments of Czechoslovakia, Denmark, France, Greece, Israel, Sweden, and Yugoslavia have requested WHO assistance in establishing training centres for anaesthesiology. Widespread interest in this relatively new speciality is due, at least partly, to experience gathered during the second World War. Modern anaesthesiology has effectively contributed to diminishing surgical mortality-rates by preventing complications in the operating-room and during the postoperative period. Other significant aspects of up-to-date anaesthesiology, as practised in Canada, the United Kingdom, and the USA, have gained recognition in many other countries where the new speciality has not yet been introduced. Among these aspects are the new vistas that have been opened up to surgery ; the increasing desire of obstetricians, internists, psychiatrists, etc. to consult with, and to use the services of, an anaesthesiologist ; and the recognition by hospital administrators and health authorities of the advantages of an anaesthesiology department to hospital management. Public-health administrations in Denmark and Sweden, for instance, have developed plans to provide at least one fully trained, full-time anaesthesiologist for each hospital in the country. Even in countries where anaesthesiology is already a firmly rooted speciality, adequately trained anaesthesiologists are not available in such numbers. It will take several years to train the required numbers of such personnel in the Scandinavian region, and the WHO training centre for anaesthesiology in Copenhagen is designed to assist the governments in carrying out their plans. More recently, in France, the Ministère de la Santé publique et de la Population, in co-operation with the Ministère de l'Education nationale and with the medical faculty of the University of Paris, has developed similar plans.

The training centre for anaesthesiology in Copenhagen was opened on 1 May 1950.[1] It is operated jointly by the Danish State Medical Board (Sundhedsstyrelsen) and the University of Copenhagen on the one hand, and by the World Health Organization on the other. Four of Copenhagen's largest hospitals are engaged in the teaching programme : the University Hospital (Rigshospitalet), the Municipal Hospital, the County Hospital (Københavns Amtssygehus), and the Bispebjerg Hospital. Professor E. Husfeldt, selected jointly by the Government and the Faculty, is in charge of the administration of the training centre, with Dr E. W. Andersen, Chief Anaesthetist, Copenhagen County Hospital, acting as secretary. The teaching programme proper is the responsibility of senior instructors provided by the World Health Organization.

[1] *Chron. World Hlth Org.* 1950, 4, 191

Originally, training of physicians from only the Scandinavian area was contemplated ; however, requests have also been received from countries outside the area, and the Danish Government has agreed to the admission of some of these physicians. Besides the Danish trainees, there are at present one physician from Sweden, four from Norway, three from Finland, one from Iceland, one from Yugoslavia, and two from Austria receiving training, bringing the total number of trainees to twenty for the first-year course of the training centre.

FIG. 2. ANAESTHESIOLOGY TRAINING CENTRE, COPENHAGEN, I

Dr S. C. Cullen, Professor of Anaesthesia at the State University of Iowa, USA, is shown giving a demonstration at the training centre. Looking on are Dr R. M. Waters (centre), former Professor of Surgery and Anaesthesiology at the University of Wisconsin, USA; Dr E.W. Andersen (extreme right), Anaesthetist-In-Chief, Copenhagen County Hospital ; and a group of trainees

WHO assistance to the Danish Government essentially consists of the following contributions :

1. Expert advice in organizing and operating the training centre.

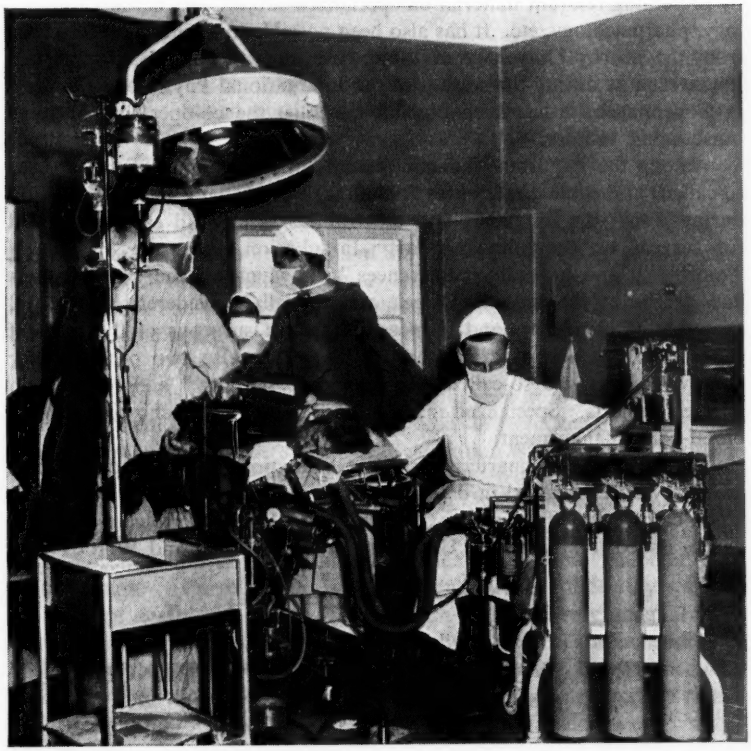
2. Granting of fellowships to non-Danish trainees. Danish trainees are not entitled to fellowships according to existing regulations ; however, they are being provided with necessary textbooks, just as are non-Danish participants in the course.

3. Provision of a fairly comprehensive selection of texts and monographs on anaesthesia to serve as a reference library for the training course. Three different models of anaesthesia machines and various accessory equipment that were not available in Denmark have also been provided, thereby making it possible for the trainees to work with various types of apparatus.

4. Provision of the foreign teaching staff for the entire duration of the courses.

The services of instructors of highest international standing are being sought and acquired. The names of Professors S. C. Cullen and R. M.

FIG. 3. ANAESTHESIOLOGY TRAINING CENTRE, COPENHAGEN, II



Modern methods of anaesthesia in practice in the operating-room

Waters, of the USA ; of Dr C. Grey and Dr W. Mushin, of the United Kingdom ; and of Professor T. Gordh, of Sweden, make an impressive list of senior instructors for the current course. Besides these senior instructors, a number of fully qualified junior instructors from the United Kingdom and the USA assist the senior chief in his work.

The blue-print for the organization of the centre and its curriculum is being developed by Professor Cullen, of the State University of Iowa. Trainees undergo intensive training in the operating-room, where they work under the supervision of their local or foreign instructors. Operating-room work takes up more than half the day and is followed by a regular schedule of lectures and conferences, covering basic sciences, public-health aspects, and clinical problems. Danish and foreign instructors in anaesthesiology give most of the lectures ; however, professors of the medical

faculty of the University of Copenhagen augment these lecture programmes by presenting relevant material on specialized subjects in anatomy, physiology, pharmacology, etc. It has also been possible to secure guest lecturers, from the nearby University of Lund, Sweden, for example. At certain times, such as during the session of the International Physiology Congress in Copenhagen, it has been possible to enlist the co-operation of some outstanding visitors.

Among the important didactic features of the training course are the so-called " schedule conferences ", that take place daily in each hospital, during which the instructor and the trainees discuss all cases scheduled for surgery on the following day. In addition, there are the weekly " morbidity and mortality conferences ", at which all the complications and deaths in the preceding week are critically considered by the full assembly of instructors and trainees, with chief surgeons of the relevant departments participating frequently. There are also two other regular weekly lectures, the so-called " basic science seminar " and lectures on selected subjects. Specialized instruction is given in bronchoscopy and in blood-bank management.

Trainees undergo quarterly written examinations. Examination papers are afterwards discussed in detail orally by the instructor and the trainee. Upon completion of the course, trainees will receive a certificate of attendance, issued jointly by the University of Copenhagen and WHO.

FIRST WHO REGIONAL CONFERENCE ON HEALTH STATISTICS

Without the aid of health statistics, only an incomplete picture of the state of health of a people can be obtained, which makes it difficult to draw up appropriate programmes and, subsequently, to judge their effectiveness. Improvement of health statistics has been considered at several international meetings attended by experts from all parts of the world. However, because of the diversity of conditions from one country to another, the recommendations made at these conferences could be only of a general nature. The study of the problem on a regional rather than a worldwide basis could be more fruitful. With the aim of studying means of improving health statistics in the Eastern Mediterranean Region, the first WHO Regional Conference on Health Statistics met at Istanbul, Turkey, on 8 and 9 September 1950. It was attended by representatives from Egypt, Ethiopia, France, Iran, Iraq, Israel, Lebanon, Pakistan, Saudi Arabia, Syria, Turkey, and the United Kingdom. Dr K. Olcar (Turkey) was elected Chairman, Dr Salem Abd El Maguid (Egypt) Vice-Chairman, and Dr A. J. Rizali (Iraq) Rapporteur.

Improvement of Health Statistics

The primary requisite of health statistics is reliable population figures. The conference therefore stressed the importance which governments should accord this question and recommended that methodically conducted national censuses be taken at regular intervals and that, when official publications give figures for " estimated " population (i.e., not established by census), the method used to make such estimates should be clearly stated.

Incorporation into national laws of the new definitions proposed by the Subcommittee on the Definition of Stillbirth and Abortion [1] and adopted by the Third World Health Assembly would also lead to improvement in the registration and value of demographic data, particularly those concerning birth. The conference therefore requested all countries to make use of these definitions as soon as possible in their own statistical practice.

As regards mortality statistics, the conference recommended that in compiling them attention be paid to the place of residence of the deceased persons. In countries where medical organization is not very highly developed it is frequently possible to obtain proper medical care only in large towns. Consequently, sick persons go there in large numbers and, in the event of their death, an element of error is introduced into the statistics since mortality appears much higher in such centres than in other parts of the country. Furthermore, in the interpretation of mortality statistics by cause of death, it is necessary to bear in mind the very unequal value of data based on observations made by qualified medical staff as compared with those referring to deaths where the cause has not been medically certified. The reliability of diagnosis in this latter category may be rightly and strongly doubted, and very critical judgement should be exercised in this respect. Consequently, the conference recommended that, in the future, a clear separation be made on statistics by causes of death between those which have been medically certified and others. Moreover, it is to be hoped that the proportion of the latter will gradually decrease.

It will be the responsibility of national administrations to implement these various recommendations with a view to obtaining reliable health statistics. The same aim could be attained more rapidly if an interest in statistics could be aroused in physicians and hygienists, and a systematic study of these problems made. For this reason the conference requested the various governments of the region to set up national committees on vital and health statistics to study the special problems which arise in each country and to ensure international co-ordination in this field, WHO acting as intermediary.

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[1] *World Hlth Org. techn. Rep. Ser.* 1950, **25**, 11 ; see also *Chron. World Hlth Org.* 1950, **4**, 174.

Centralization of Data

Another task which WHO and its regional organizations must fulfil is the collection of a certain amount of basic statistical information so as to give an adequate picture of the situation in each country and permit the elaboration of appropriate health programmes. The conference therefore requested the Regional Director to submit to governments of the States of the region a list indicating the various vital and health statistics which they would have to supply to the Regional Office. The governments, in turn, will formulate and submit their observations, a necessity since they are perhaps not all in a position—owing to lack of suitable institutions or qualified staff—to collect as complete information as might be desired and must, therefore, qualify the minimum list of fundamental statistical data to be furnished by each country.

A similar effort will be undertaken to standardize the different types of forms and reports concerning vital and health statistics.

Training of Personnel

The different ways of approaching the question of improvement of health statistics show that one of the essential problems to be solved is that of the statistical training of medical personnel. The conference therefore adopted the resolution on this subject which was adopted by the Expert Committee on Health Statistics [2] and noted by the Second World Health Assembly. This resolution stresses the importance of :

(1) elementary training in statistical methodology for all medical students ;

(2) more-advanced teaching of the same subject to physicians training for posts in public-health administration ;

(3) instruction in the elements of medical statistics for non-medical personnel engaged in certain statistical work.

These measures, however, can give tangible results only after some time. The conference therefore drew up a proposal, along the same lines, which can be put into effect immediately. This consists of the possible organization, under the joint auspices of the United Nations and WHO, of a regional instruction course in vital and health statistics for medical personnel and those specially concerned with these questions in the competent national services. It likewise suggested the setting-up of a shorter course for auxiliary statistical personnel. The representative of Iran, on behalf of his government, proposed that the centre be established in his country and offered all the necessary facilities.

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[2] *World Hlth Org. techn. Rep. Ser.* 1950, 5, 10 ; see also *Chron. World Hlth Org.* 1949, 3, 250.

LYMPHOGRANULOMA VENEREUM

Lymphogranuloma venereum, which has been described under various names, such as lymphogranuloma inguinale, Frei's disease, Nicolas-Favre disease, and fourth venereal disease, is caused by a specific virus. The skin test introduced by Frei in 1925 has made possible studies which have shown that the geographical distribution of this disease is more extensive than had been supposed, that it is, in fact, worldwide, though its incidence is greater in the tropics.

The epidemiology, etiology, clinical aspects, diagnosis, and treatment of lymphogranuloma venereum are the subject of a comprehensive and up-to-date review, appearing in a recent number of the *Bulletin of the World Health Organization*,[1] by Professor W. E. Coutts, Chief of the Department of Social Hygiene, Public Health Administration, Santiago, Chile, and member of the WHO Expert Committee on Venereal Infections.

This disease is generally of venereal origin. However, other possible sources of infection, such as unnatural sexual intercourse and accidental contagion of the kind which might occur in the laboratory, should not be ignored. In addition, the existence of asymptomatic carriers has been proved.

Lymphogranuloma venereum is caused by a virus of a lymphotropic nature. This lymphotropism is responsible for the differentiation in the type of involvement observed in clinical practice, as infection spreads mainly along the lymphatics. The virus is active at room temperature for 24-28 hours and remains active after drying for 30 days.

The clinical manifestations may be grouped into three stages : primary, secondary, and tertiary. The initial lesion appears on the genitalia, rectum, mouth, etc., from 10 to 30 days after exposure. This lesion is generally an ulcer, with clear-cut edges surrounded by a reddened zone and with a whitish-grey base. A local or regional oedema forms, producing phimosis in men and swelling of the external genitalia in women. These primary manifestations are accompanied by inflammatory symptoms at the site of infection—urethritis, vaginitis, proctitis, stomatitis, etc. Adenopathy appears in the lymphatic drainage-area corresponding to the site of penetration of the virus. In many cases (50%-70%) the bubo is the first noticeable sign of the disease but it is actually only one of a complex of manifestations which are symptoms of the secondary period. The appearance of the bubo is accompanied by a sensation of stiffness and aching. The process extends until all the glands of the group are involved, the infected lymph-nodes forming one conglomerate mass and adhering to the skin covering them, which is of a rather characteristic purplish colour. Softening then occurs in one or more zones, and formation of abscesses and fistulas, from which first pus and later a sero-viscid fluid drains, is a characteristic feature.

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[1] *Bull. World Hlth Org.* 1950, 2, 545

The adenopathy usually subsides after 2 or 3 months but draining sinuses may persist for a much longer period. The location of the buboes depends on the site of the initial infection. In 75% of cases there is involvement of the deep iliac lymph-nodes. This is frequently accompanied by complications due to the inflammation of these glands, and diagnosis becomes difficult, particularly if the primary manifestations are not characteristic.

The constitutional reactions are not specific but may overshadow the local manifestations of lymphogranuloma on account of their severity. They include fever, headache, vomiting, rheumatoid manifestations, etc. The disease is accompanied by secondary anaemia and leucocytosis ; the erythrocyte sedimentation-rate is considerably increased, and hyperglobulinaemia and decrease of serum lipids are also observed. After the secondary period, many patients become asymptomatic. Others present extremely varied clinical pictures, the syndromes corresponding to manifestations appearing on or around the genitalia.

The tertiary stage is marked by symptoms such as esthiomene, urethro-genito-perineal syndrome, elephantiasis of the penis and scrotum, rectal stenosis, and plastic induration of the penis. Esthiomene is characterized by a chronic ulcerative process which appears on the external surface of the labia majora, on the genito-crural folds, lateral and anterior regions of perineum, mons veneris, etc. The urethro-genito-perineal syndrome is characterized by the appearance of penile, scrotal, or perineal sinuses from which drains a sero-viscid fluid or urine or a mixture of both. It may be present with or without urethal stenosis. Rectal stenosis may present itself as the only manifestation of the disease, or as a complication or integrant of genital syndromes, and appears from 1 to 10 years or more after the initial infection. Other manifestations affecting the skin, cardiovascular system (pericardial symphysis, arteriosclerosis, obliterative arteritis, etc.), respiratory system, digestive system (glossitis, oesophageal ulcers, gastritis, cholecystitis, etc.), and nervous system have also been described.

Diagnosis may be made by various methods and procedures, including Frei's intracutaneous test, the complement-fixation test, culture of the virus, and histopathological changes. Routine diagnosis is based principally on Frei's intracutaneous test. This highly specific reaction is characterized by the appearance of a papule of 6×6 mm., with surrounding erythema, 48-72 hours after injection of the specific antigen. The results obtained with the complement-fixation test have been shown to be more specific than those with the intracutaneous test. Other advantages of the former test are that it makes mass-screening of population groups possible and that it can be carried out at the same time as serological examination for syphilis.

Up to the present time, medical and surgical therapies have been rather unsatisfactory. The sulfonamides and most of the antibiotics have not proved very useful. However, more encouraging results have been obtained

with aureomycin. One week after treatment had begun, no elementary or inclusion bodies could be detected from smears made by aspiration of buboes. In patients suffering from proctitis, definite improvement was noted after 4 to 8 days.

THIRD INTERNATIONAL DIGITALIS STANDARD

Digitalis is one of the 37 substances for which international standards have been established during the past 25 years. The first digitalis standard was adopted in 1926 by the Permanent Commission on Biological Standardization of the League of Nations Health Organization. Owing to the demand, stocks of the standard were exhausted in 1935 and a second standard was therefore prepared. In 1947, when this supply also was running out, the Expert Committee on Biological Standardization of the World Health Organization authorized the Department of Biological Standards of the National Institute for Medical Research, London, to make arrangements for renewal of the standard.

In a recent article in the *Bulletin of the World Health Organization*[1] Dr A. A. Miles, Director of the Department of Biological Standards of the National Institute for Medical Research, London, and Dr W. L. M. Perry of the Department of Physiology and Pharmacology of the same institute, describe the various stages in the preparation and assay of the new standard.

The material for the preparation of the standard was obtained by mixing six batches of digitalis powder procured from three different countries (USA, United Kingdom, and Switzerland). The biological assay against the second standard was carried out in 16 laboratories of eight different countries.

The authors give a statistical analysis of the results of all the assays and describe the methods employed to obtain, by a combination of these results, a potency unit for the new standard. The unit of the third international digitalis standard is defined as the activity contained in 76 mg. of the standard preparation. This unit differs very little from that of the second standard, which was defined as the activity contained in 80 mg. of the earlier preparation.

A comprehensive annex includes details of the procedures prescribed to the laboratories for the cat, guinea-pig, and frog assays. It is known that there is not complete agreement between the results of assays on different animals. The authors also explain the advantages and disadvantages of each procedure.

[1] *Bull. World Hlth Org.* 1950, 2, 655

RECENT ENTOMOLOGICAL RESEARCH

Two articles on insect disease-vectors have just appeared recently in the *Bulletin of the World Health Organization*. The first, by Dr Karl Jordan, formerly Director of the Zoological Museum, Tring, Hertfordshire (England) is entitled " Notes on a collection of fleas from Peru ".[1] Twenty species of fleas collected in 1946 and 1947 during the investigation of outbreaks of wild-rodent plague in certain districts of Peru were identified at the Zoological Museum, Tring. Four of these species were previously unknown and a detailed description of them is given. Several of the others were new for Peru. The resemblance between some of the specimens and certain northern species raises interesting questions regarding the geographical distribution and evolution of the various species ; certain subspecies may represent stages in their evolution.

In a study entitled " Malaria along the Mexican-United States border ",[2] Dr L. Vargas of the Instituto de Salubridad y Enfermedades Tropicales and of the Dirección de Cooperación Interamericana de Salubridad Pública, Mexico, gives a list of species of *Anopheles* which are encountered on both sides of the frontier between Mexico and the USA and which play an important role in the transmission of malaria. Dr Vargas surveys the geographical distribution and characteristics of the different species. *Anopheles freeborni*, *A. pseudopunctipennis typicus*, *A. quadrimaculatus*, and *A. albimanus* may be considered as the most frequent malaria vectors in the region.

[1] *Bull. World Hlth Org.* 1950, 2, 597
[2] *Bull. World Hlth Org.* 1950, 2, 611

INFANT MORTALITY IN ICELAND

An improvement in general living conditions and the standard of education in a country generally results in a decline in the infant mortality-rate. This phenomenon is well illustrated by the case of Iceland, as pointed out by Dr J. Sigurjónsson, Professor of Hygiene at the University of Iceland.[1]

The infant mortality-rate in Iceland has shown a continuous decrease, amounting roughly to 20%-22% per decade during the last century, so that it is now less than one-tenth of what it was a hundred years ago. This trend has accompanied a rise in the standard of living and sanitary conditions of the country, although special child-welfare services are of recent origin. A tenfold increase in the number of doctors is another factor which has contributed to the decreasing infant death-rate.

[1] *Bull. World Hlth Org.* 1950, 2, 723

The average rate for the period from 1941 to 1947 was 33.7 deaths per 1,000 live births ; the lowest value reached for a single year was 22, in 1947. Until 1945, the decline in the rate of mortality of infants under one month in age was as significant as that of the total infant death-rate. Since 1911, the decrease in deaths from respiratory diseases and gastro-intestinal disorders has been most marked, whereas death-rates due to prenatal and natal causes have remained almost stationary at just below 20 per 1,000 live births. It is hoped that, through better care of women during pregnancy and delivery, it will be possible to reduce the number of deaths due to prenatal and natal causes so that the total infant mortality will be below 20 per 1,000 live-born children during the next decades.

EVOLUTION OF MORTALITY IN EUROPE, 1900-1947

A new contribution to the series of studies on mortality in Europe during the twentieth century has just appeared in the *Epidemiological and Vital Statistics Report*.[1] Data concerning mortality by sex and by age, without distinction as to cause of death, have been analysed by Dr M. Pascua, Deputy Director, Division of Health Statistics, WHO.

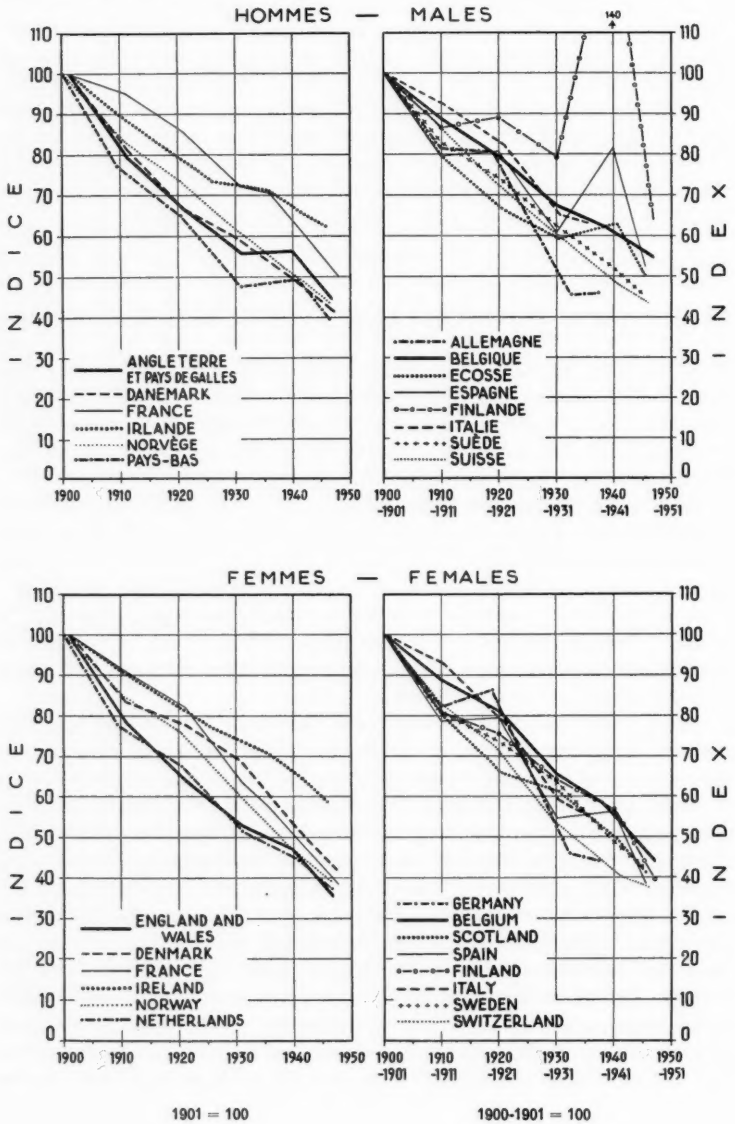
As stressed by the author, the accuracy of the statistics is not the same in all countries. Errors may arise, particularly those due to incorrect data concerning age supplied by the population during censuses and to the relative number of deaths classified under the heading "age unknown". Thus all the data cannot be accepted as strictly accurate. However, it would be merely empty scepticism to refuse to believe the information at our disposal, which clearly reveals a considerable fall in mortality in Europe. This decrease is of the order of 40%.

After having indicated on what basis the statistics have been analysed and the periods considered in the various countries, Dr Pascua reviews the evolution of mortality by age-group and by sex in each of the following countries : Belgium, Denmark, England and Wales, Finland, France, Germany, Ireland (not including Northern Ireland), Italy, the Netherlands, Norway, Portugal, Scotland, Spain, Sweden, and Switzerland. The following are some of the general conclusions drawn by the author from this study :

The fall in infant mortality, as a whole, exceeds 50%. In certain countries (Denmark, England and Wales, the Netherlands, Sweden, and Switzerland) the infant mortality-rate is one-third lower than at the beginning of the century. Among children of preschool age (1 to 4 years), the fall in mortality is still more striking. In certain countries the mortality-rate is about a quarter of that of 1900-1901. It is interesting to note in this connexion that the movements of relative decline have been similar in a large number

[1] *Epidem. vital Stat. Rep.* 1950, 3, 30

FIG. 4. TREND OF MORTALITY IN AGE-GROUPS UNDER 65 YEARS



of countries with great differences in their public-health organization, medical care for children, and social and economic conditions. The analysis of mortality by cause of death, which will be subsequently studied, will, no doubt, help to explain this problem.

For other age-groups up to 45 or 50 years, the specific mortality-rates have been reduced by at least half in the majority of the countries considered, with the exception of Ireland. In Belgium and Spain, however, at least in the case of males, the decrease is not so pronounced. In a general way, for ages below 65, a continual and distinct decrease can be noticed, the present mortality-rates ranging between 40% and 60% of what they were at the beginning of the century.

As concerns the age-group of 75 and above, some fluctuations of the specific mortality-rates can be observed during the half century, a general fall of 10% to 15% being evident around 1946. This figure has been exceeded in the Netherlands, where the decline has been clearly marked since the end of the second World War. In Sweden, on the other hand, there has been no decrease in mortality-rate for this age-group.

In all countries, the lowest mortality-rates, both at the beginning of the century and in more recent periods, have been registered for the age-group of 10 to 14 years.

The second factor whose bearing on mortality has been considered in this study is sex. Are there any appreciable differences in mortality according to sex ? In the recent period, and for all ages, it is found that the mortality-rate for males is higher than that for females, the ratio of the two rates reaching 1.23 in Spain in 1946 and 1.19 in England and Wales in 1947. Only Sweden shows equal rates for both sexes.

The mortality of male babies has always been higher than that of female babies, the difference amounting sometimes to 20%-25%. In the Iberian Peninsula and in Italy, however, the difference has been less pronounced, the quotient frequently being only 1.12.

At the beginning of the century, the mortality among boys of school-age was lower than that among girls. At present the reverse is observed, and the quotient varies between 1.40 and 1.50 for children aged 5 to 9 (Denmark, Norway, Sweden, Switzerland). It often exceeds 1.20 for the 10 to 14 age-group (Denmark, England and Wales, France, Germany, Italy, Norway, the Netherlands, and Scotland).

As regards ages between 15 and 75, a similar phenomenon is seen ; the mortality of males in recent periods has been definitely higher than that among females, quotients reaching 1.60 or 1.70 not being uncommon in middle age. Generally speaking, this difference in mortality-rates between the sexes was not so pronounced at the beginning of the century. At that period the quotients of the rates were not far from 1. It is certain that the after-effects of the two world wars are reflected in these figures. However, in Ireland no significant difference can be observed between the mortality-

rates for the two sexes. The quotient of the rates remains at about 1 for ages between 15 and 50. In Denmark there is a tendency for the rates to be equal.

For persons aged 75 years and above, the quotient of the mortality-rates by sex has varied only slightly during the half century. The mortality-rate for men in this age-group is generally 10% to 15% higher than that for women in the same group. This difference is lower in the Scandinavian countries and the Netherlands.

The author has tried to give a tentative estimate of the number of deaths which would have occurred around 1947 if the mortality-rates had remained the same as at the beginning of the century. He also gives the theoretical number of lives " saved ". The population of 13 of the countries in question, for which information relating to 1947 is available, comes to 203,000,000. If the mortality-rates had remained constant since 1900, there would have been 4,187,000 deaths in 1947 for all age-groups, i.e., 1,750,000 more than the number actually observed. The decrease in mortality may therefore be put at 42%. The " saving in human life " among babies was 60%. It amounted to 69% for children aged 1 to 5 and 18% for persons aged 75 years and over.

Reports from WHO Fellows

Many of the letters and reports received from WHO Fellows have been of such interest that they deserve to be read by a wider public. They demonstrate more vividly than a series of facts and figures both the nature of the fellowship programme and the response of the Fellows themselves. Selections from these reports are therefore published from time to time, but it must be emphasized that the opinions expressed are those of the Fellows.

The Architecture of Hospital Buildings

Mr S. Kliska, Professor at a technical school in Belgrade (Yugoslavia), made a three months' study-trip as a WHO Fellow. He went to Denmark, England, Sweden, and Switzerland in order to visit the principal hospital buildings in these countries and to study present architectural trends in this field. Below is some of the information which he obtained during his visit to Sweden, a country where the hospital services are being greatly expanded.

The modernization of the Swedish hospital system has provoked much discussion in interested circles. Although new hospitals have been constructed, the greater number of beds is still found in the older ones ; and despite construction carried out during the war, the hospital services do not yet completely cover all needs.

According to Mr Kliska, the first question which arises is whether the older hospitals should be remodelled or whether new ones should be constructed. Because of the spread of blocks of flats and of industrial buildings, it is often difficult to find a suitable site for a new hospital in large towns. Consequently, the problem becomes one of determining how hospitals which are satisfactorily situated can be retained, with services being continued while modernization is taking place. Some attempts in this direction have been made, such as partial reconstruction, or remodelling and adaptation to new medical needs. On the whole, such efforts have been rather unsatisfactory ; therefore, the necessity of constructing rather than reconstructing demands attention.

Another question must then be answered : what type of hospital is preferable ? A number of architects are in favour of total centralization, as opposed to the so-called " pavilion " system. In Stockholm, Mr Kliska was able to visit two large modern hospitals, one of which, the Karolinska Hospital, includes pavilions for the psychiatric services, a radium institute, and other separate departments in addition to the central building. While recognizing the advantages of some degree of decentralization, Mr Kliska feels that the Karolinska Hospital does not serve as a good example of the value of this idea ; centralization, if it can include exceptions in certain specific cases, would seem preferable.

As regards the distribution of the various services, the relationship between hospital and polyclinic should be defined. The hospitals mentioned above both have polyclinics as an integral part of the central block. It may be noted that in certain modern layouts the polyclinic governs the planning of the structure as a whole, e.g., the Smöeslettet Hospital at Göteborg. It is the nature of the duties carried out by the polyclinic which determines to what extent contact with the hospital should be maintained. If the polyclinic is utilized—as was formerly the case—for the treatment of patients after their discharge from the hospital, or as a training centre, it is indispensable for it to form part of the hospital. On the other hand, if it is assumed that the polyclinic plays a more important role and that it should have a separate organization, then there is no reason for connexion with the hospital other than that provided by the admitting department.

Advances in medicine and changing methods of treatment have caused considerable alterations in hospital services. Furthermore, improvement in social conditions, which enables a greater number of people to benefit by hospital treatment, makes it necessary to arrange for a sufficient number of beds to cover all needs. For these and other reasons, the modern hospital should be planned so that it can be readily enlarged.

The opinions of Swedish architects vary with regard to the placement of facilities such as the main kitchen and the staff residence quarters. Whereas formerly the kitchen was placed on the top floor of the building, the present tendency is to install it on a lower floor, though not in the basement. It has been recognized that staff quarters should be constructed outside the hospital proper, so that the staff may enjoy greater freedom of movement.

Mr Kliska paid particular attention to the activities of two bureaux which have been set up in Sweden for the improvement of hospital architecture and the organization of medical institutions. These bureaux come directly under the Ministry of Internal Affairs and work in co-operation with the Director of Public Health, and through them Mr Kliska was able to consult with leading Swedish architects who participate in the research work of the bureaux.

Notes and News

International Training Centre for Biostatistics

International training and study centres for biostatistics (vital and health statistics) are to be organized in various countries on the model of the meetings devoted to statistics and censuses which recently took place in Mexico City, Cairo, and New Delhi. These centres, in whose formation WHO is particularly interested, will have the task of organizing refresher courses for personnel dealing with biostatistics in national administrations. They will thus make an important contribution to the improvement of statistical methods in use in the different countries and help thereby to increase the efficiency of their statistical services.

The first Inter-American Seminar for Biostatistics has been organized in Chile with the assistance of WHO. It will deal mainly with statistical methods, and the co-ordination which should exist between different institutions in the same country, i.e., registry offices, services for health statistics, central statistical offices, etc. The courses will last about three months so that the instruction given may have the required technical character.

The various problems raised by vital and health statistics will be approached above all from the practical point of view. The participants will certainly not all have the same range of knowledge. Consequently, it will be necessary, regardless of the nature of their previous training, to teach them first the essential elements of statistics ; provision is also made for more advanced courses.

The discussion meetings, because of their non-theoretical character, will deal with a restricted number of subjects and include a study of the problems most frequently encountered. Special attention will be paid to practical work so as to enable all students to benefit by the experience already acquired in countries other than their own.

WHO Assists in Paediatrics Training Activities in India

WHO is furnishing technical guidance and assistance in a joint project of the Government of India and the United Nations International Children's Emergency Fund (UNICEF) for the development of a modern training centre in paediatrics in Delhi Province. UNICEF funds will be used to provide personnel and equipment for a maternal and child health project already taking shape in a rural area of the province and for enlarging and improving Delhi hospital facilities to serve as a training centre for paediatricians and paediatric nurses from all parts of India.

Dr B. Landtman (Finland) and Miss N. Toy (Canada) form a WHO team which has been attached to the staff of the Irwin Hospital, New Delhi, to give practical assistance in this project. Dr Landtman is a specialist in paediatrics who worked in the Children's Hospital of the University of Helsinki and, subsequently, in children's hospitals in London and Stockholm. Miss Toy taught at the Toronto Hospital for Sick Children and was on the staff of the Montreal Child Health Association in Canada. In addition to her present work at the Irwin Hospital, she is teaching paediatric nursing to students at the Delhi College of Nursing.

Bejel-Control Project in Iraq

Acting upon recommendations of the Expert Committee on Venereal Infections,[1] WHO is assisting in a bejel-control project which is being undertaken by the Government

[1] *Chron. World Hlth Org.* 1950, **4**, 37

of Iraq, with the support of the United Nations International Children's Emergency Fund. Bejel, which is believed to be a form of endemic syphilitis, is widespread among certain nomadic and semi-nomadic populations in the Eastern Mediterranean area. The project for its control in this area will be based on penicillin treatment, which has proved highly effective against other treponematoses. Epidemiological and laboratory studies will be carried out concomitant with the control measures.

Dr E. H. Hudson, Director of Health Service, Ohio University, and author of *Treponematosis*, a standard work on the subject, has been named chief medical adviser for the project. Dr Hudson left for Baghdad early in October to begin preliminary operations. Additional WHO personnel are expected to join him later.

Relief to the Civilian Population in Korea

Following an appeal from the United Nations, WHO has appointed a mission to Korea to assist in the relief and support of the civilian population. The mission will work under the Unified Command.

Dr Walter H. Crichton (United Kingdom), director of the mission, will act as adviser to the Ministry of Public Health and Social Affairs of Korea and will maintain liaison between the Unified Command and the Ministry. Dr Crichton has wide experience in public-health administration and epidemic control campaigns. He will be assisted by another public-health administration officer.

Five teams, each consisting of a public-health officer and a sanitary engineer or sanitary inspector, will advise the local health authorities on the control and prevention of epidemics and on sanitation problems.

Rural Health Demonstration and Training Centre in the Philippines

The Government of the Philippines, with assistance from the United Nations International Children's Emergency Fund (UNICEF) and WHO, is opening a rural health demonstration and training centre at which health personnel of many types will receive instruction. Special emphasis will be given to maternal and child health, but the centre will also be concerned with the prevention and control of communicable diseases, tuberculosis and malaria control, nutrition, sanitation, vital statistics, health education, nursing services, and other important public-health problems.

Dr C. Ferrufino (Bolivia) has been appointed by WHO to serve as consultant on maternal and child health activities in this project. Dr Ferrufino received his medical training in Santiago, Chile, and at Harvard University, USA. He is chief of the medical division of the Servicio Cooperativo Interamericano de Salud Pública and teaches child hygiene and care in various institutions. He was formerly General Inspector of Health in Bolivia ; he also served with UNRRA as Chief Medical Officer in displaced persons assembly centres.

Assisting Dr Ferrufino in his Philippines assignment will be a WHO nurse, Miss W. Visscher, who was formerly with the maternal and child health team in Korea.

Nursing Conference Held in Leyden

In early October a two-week conference on nursing was held in Leyden, the Netherlands. Forty-four public-health nurses from Belgium, Denmark, England, Finland, France, Ireland, Luxemburg, the Netherlands, Norway, and Sweden attended this conference, which was organized by the Netherlands Government and WHO. Professor R. Remmelts, Director of the Institute of Preventive Medicine, Leyden, directed the

conference. In addition to representatives of WHO, speakers included several Dutch health officials.

This was a " working " conference at which views were exchanged on problems facing the nurse today and on the role of the nurse in the light of new trends in public health. Among the special topics discussed were health education, mental health, nutrition, and the social aspects of public-health work.

CORRIGENDUM

1950, Vol. 4, No. 7-8, p. 224

Line 27 : *for* Old tuberculin..... 0.01 ml.
read Old tuberculin..... 0.00001 ml.